Exhibit 11

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Kaopua, Milton K.
2. Social Security Number: 575-50-0532
3. Date of birth: Mo. 4 Day 24 Yr. 47
4. Sex: [X] Male [ ] Female
5. Home telephone: (808) 695-5199
6. Grade as of date of injury: Level 7 Step 10
7. Employee's home mailing address (Include city, state, and zip code): 84-710 Kili Drive, Apt. 1313, Waianae, HI 96792
8. Dependents: [X] Wife, Husband [ ] Children under 18 years [ ] Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Fire Station - 11 - Lualualei
10. Date injury occurred: Mo. 10 Day 13 Yr. 01 * | Time: [ ] a.m. [ ] p.m.
11. Date of this notice: Mo. 11 Day 26 Yr. 01
12. Employee's occupation: Fire Captain
13. Cause of injury (Describe what happened and why) *and continuing.
Captain Abad threatened my life in a statement made on 10/10/01 to Colin Hallb

My superiors refuse to take action to protect me and have punished me through a transfer to station 14B.

a. Occupation code:
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)
Increased high blood pressure, inability to sleep, anxiety action and depression.
b. Type code: 37
c. Source code:
OWCP Use - NOI Code:

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

[X] a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

[ ] b. Sick and/or Annual Leave

Signature of employee or person acting on his/her behalf: Milton K. Kaopua

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

End of Employee Report

Witness

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness | Signature of witness | Date signed

Address | City | State | Zip Code

220

ENCLOSURE (1)

CA-1 (Rev. 3/86)